New Hampshire Retirement System, 4 Chenell Drive, Concord, NH 03301-8509, (603) 271-3351

EMPLOYEE'S STATEMENT OF DISABILITY

____ Ordinary Disability ____ Accidental Disability

MEMBER INFORMATION PLEASE PRINT

Date _____ SS# _____

Name _____ Occupation _____

Employer Name _____

Address _____

Supervisor's Name & Title (or other Employer Contact): _____

Worker's Compensation Insurance Carrier (for Accidental Disability claims only):

_____

INCAPACITY INFORMATION PLEASE PRINT

Date of onset of disability (illness, condition or injury) _____

Nature of disability (explain) _____

_____

_____

_____

State the reason(s) why you are no longer able to perform the duties of your position, and why this incapacity is total and likely to be permanent _____

_____

_____

_____

A copy of this document will be submitted to your employer.

CERTIFICATION

I certify that the above report, under the penalties of perjury, is true.

_____ _____

(Signature of Member) *(Date)*

Counselor Initials _____

C NHRS 7 7/2002